Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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347 Preston St, 4th Floor
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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Nov 21, 2013	2013_196157_0024	000108, 000261, 001008	Complaint

Licensee/Titulaire de permis

EXTENDICARE CENTRAL ONTARIO INC
82 Park Road North, OSHAWA, ON, L1J-4L1

Long-Term Care Home/Foyer de soins de longue durée

EXTENDICARE HALIBURTON
167 PARK STREET, P.O. BOX 780, HALIBURTON, ON, K0M-1S0

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

PATRICIA POWERS (157)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): November 4, 5, 6, 2013

This inspection was related to the following logs: 000108-13, 000261-13, 001008-13

During the course of the inspection, the inspector(s) spoke with the Administrator, RAI Coordinator, Program Manager, Behaviour Support Registered Practical Nurse (RPN), Physician, 2 family members, 4 Personal Support Workers (PSW's), 2 Registered Nurses (RN's), 2 Registered Practical Nurses (RPN's), 4 residents.

During the course of the inspection, the inspector(s) reviewed the clinical health record of an identified resident, observed the behaviours of an identified resident, observed resident:resident interactions, observed staff:resident interaction, reviewed licensee policies related to residents who wander, responsive behaviours,

The following Inspection Protocols were used during this inspection:
Critical Incident Response

Responsive Behaviours

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend	Legendé
WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités

Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that the written approaches to care of residents demonstrating responsive behaviours, including screening protocols, assessment, reassessment and identification of behavioural triggers that may result in responsive behaviours, has been annually evaluated and updated in accordance with evidence based and/or prevailing practices. [s. 53. (3) (b)]

2. The licensee failed to identify triggers for the identified behaviours exhibited by resident #02.

Progress notes and PASE assessments for resident #02 indicate consistent, longstanding behaviours that are disruptive and intrusive to other residents.

Staff interviewed are not aware of triggers for the identified behaviours. [s. 53. (4) (a)]

3. The licensee failed to identify triggers for resident #02's frequent behaviours, as documented in the resident's progress notes, that are hazardous to the resident's health and well being.

This behaviour puts the resident at risk and there is no evidence that triggers were identified. [s. 53. (4) (a)]

4. The licensee failed to ensure that strategies were developed and implemented to respond to resident #02's responsive behaviours.

A review of the plan of care for the resident did not identify behaviours. Amendments to the plan of care made at the time of the inspection provide interventions that had already been found to be ineffective.

There is no evidence that strategies were developed or implemented to respond to resident #02's behaviours that are hazardous to the resident's health and well being.

A staff member interviewed advises that resident #02's responses to interventions vary from one day to the next. This is not identified in the plan of care and there is no evidence of an assessment of these responses to determine the most appropriate interventions.

Three residents and one family member interviewed expressed that they are upset

and frustrated that resident #02's behaviours are not being managed.

5. Resident #02's behaviour is a risk to the resident as a result of a pre-existing medical condition. There is no evidence that strategies were developed and implemented to respond to this behaviour and manage this risk to the resident's health and well being. [s. 53. (4) (b)]

6. There is no evidence that PASE recommended interventions for the management of resident #02's behaviours were implemented or evaluated.
These recommendations have not been incorporated into the plan of care and staff interviewed are not aware if these approaches have been implemented and evaluated. [s. 53. (4) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (1) Every licensee of a long-term care home shall ensure that there is a written plan of care for each resident that sets out,
(a) the planned care for the resident; 2007, c. 8, s. 6 (1).
(b) the goals the care is intended to achieve; and 2007, c. 8, s. 6 (1).
(c) clear directions to staff and others who provide direct care to the resident. 2007, c. 8, s. 6 (1).

s. 6. (11) When a resident is reassessed and the plan of care reviewed and revised,
(a) subsections (4) and (5) apply, with necessary modifications, with respect to the reassessment and revision; and 2007, c. 8, s. 6 (11).
(b) if the plan of care is being revised because care set out in the plan has not been effective, the licensee shall ensure that different approaches are considered in the revision of the plan of care. 2007, c. 8, s. 6 (11).

Findings/Faits saillants :

1. The licensee failed to ensure that the written plan of care for resident #02 provided clear direction to staff related the management of the resident's behaviours. Amendments to the plan of care made at the time of the inspection provide interventions that have already been found to be ineffective.

The written plan of care fails to provide direction for the prevention and management of the resident's behaviours that are hazardous to the resident's health and well being.

The written plan of care fails to provide clear direction for the use of medications as an intervention to manage resident #02's behaviours. [s. 6. (1) (c)]

2. There is no evidence that different approaches have been considered when the planned intervention for resident #02's behaviours was not effective. [s. 6. (11) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure the provision of clear direction in the written plan of care to staff and others who provide direct care to resident #02, to be implemented voluntarily.

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. A review of progress notes, confirmed in interviews with staff, family members and residents, indicate that resident #02 consistently demonstrates identified behaviours.

Facility Policy/Procedures "Responsive Behaviours"; Date of Origin - September 2010; Policy Number 09-05-01 directs the following:

"Each resident displaying responsive behaviours will have this behaviour observed and assessed. A resident focused care plan will be developed and maintained that includes:
- Triggers to the behaviour;
- Preventative measures to minimize the risk of the behaviour developing or escalating;
- Resident specific interventions to address behaviours
- Strategies staff are to follow if the interventions are not effective"

The plan of care for resident #02 fails to identify the resident's behaviours, triggers to the behaviours, preventative measures to minimize the risk of the behaviours developing or escalating, resident specific interventions to address the behaviours or strategies staff are to follow if the interventions are not effective.

The policy further directs the following:
"In homes with Point of Care documentation tablets, tasks focusing on reporting observed behaviour are to be added to a resident file as soon as the behaviour is observed."

There is no evidence that there is a process used in Point of Care for documentation of observed behaviours of resident #02.

The policy further directs the following:
"The care plan is to contain information related to each behaviour observed and should include at a minimum:
a. Triggers to behaviour
b. Ways to complete a task or ADL that minimizes the likelihood of the behaviour appearing
c. What the behaviour actually is - describe in detail what the behaviour will appear like
d. Interventions to deal with the behaviour

e. what to do if the interventions are not effective and/or if the behaviour escalates
f. Fluctuations in the resident's behaviour including times when the behaviour is more prevalent and times when the behaviour is non-existent"

The plan of care for resident #02 fails to identify triggers to identified behaviours, ways to complete a task or ADL that minimizes the likelihood of the behaviour appearing, a description of what the behaviour actually is and appears like, interventions to deal with the behaviour, what to do if the interventions are not effective and/or if the behaviour escalates or fluctuations in the resident's behaviour including times when the behaviour is more prevalent and times when the behaviour is non-existent

The policy further directs the following:
"If the behaviour poses a risk to the resident or others, the care plan is to outline the frequency of resident observation for safety as well as the immediate action to be taken if there is imminent risk to others"

The care plan fails to outline the frequency of observation of resident #02 for safety or the immediate action to be taken if there is imminent risk to others. [s. 8. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that established policies and procedures related to the management of responsive behaviours are complied with, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee failed to take steps to minimize the risk of altercations and potentially harmful interactions, as identified in the progress notes, between resident #02 and other residents and staff.

Inspector's observation of breakfast and noon meals on November 5 and 6, 2013; residents were observed to yell loudly and respond angrily to resident #02's behaviours. [s. 54. (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 148. Requirements on licensee before discharging a resident

Specifically failed to comply with the following:

s. 148. (2) Before discharging a resident under subsection 145 (1), the licensee shall,
(a) ensure that alternatives to discharge have been considered and, where appropriate, tried; O. Reg. 79/10, s. 148 (2).
(b) in collaboration with the appropriate placement co-ordinator and other health service organizations, make alternative arrangements for the accommodation, care and secure environment required by the resident; O. Reg. 79/10, s. 148 (2).
(c) ensure the resident and the resident's substitute decision-maker, if any, and any person either of them may direct is kept informed and given an opportunity to participate in the discharge planning and that his or her wishes are taken into consideration; and O. Reg. 79/10, s. 148 (2).
(d) provide a written notice to the resident, the resident's substitute decision-maker, if any, and any person either of them may direct, setting out a detailed explanation of the supporting facts, as they relate both to the home and to the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. O. Reg. 79/10, s. 148 (2).

Findings/Faits saillants :

1. Log #000261-13
The licensee failed to provide a written notice to the resident #03's substitute decision maker, setting out a detailed explanation of the facts supporting the discharge of the resident, as they relate to the home and the resident's condition and requirements for care, that justify the licensee's decision to discharge the resident. [s. 148. (2) (d)]

Issued on this 26th day of November, 2013

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Pat Powers #157

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c.8

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	PATRICIA POWERS (157)
Inspection No. / No de l'inspection :	2013_196157_0024
Log No. / Registre no:	000108, 000261, 001008
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Nov 21, 2013
Licensee / Titulaire de permis :	EXTENDICARE CENTRAL ONTARIO INC 82 Park Road North, OSHAWA, ON, L1J-4L1
LTC Home / Foyer de SLD :	EXTENDICARE HALIBURTON 167 PARK STREET, P.O. BOX 780, HALIBURTON, ON, K0M-1S0
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	JANE ROSENBERG

To EXTENDICARE CENTRAL ONTARIO INC, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible;
(b) strategies are developed and implemented to respond to these behaviours, where possible; and
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure that behavioural triggers are identified and strategies are developed and implemented to respond to responsive behaviours demonstrated by resident #02. The plan must include processes to seek appropriate support if implemented strategies prove to be ineffective.

This plan must be submitted in writing to MOHLTC, Attention: Pat Powers, fax (613)569-9670 on or before December 2, 2013.

Grounds / Motifs :

1. 1. The licensee failed to identify triggers for the identified behaviours exhibited by resident #02.

Progress notes and PASE assessments for resident #02 indicate consistent, longstanding behaviours that are disruptive and intrusive to other residents.

Staff interviewed are not aware of triggers for the identified behaviours. [s. 53. (4) (a)]

2. The licensee failed to identify triggers for resident #02's frequent behaviours, as documented in the resident's progress notes, that are hazardous to the

resident's health and well being.

This behaviour puts the resident at risk and there is no evidence that triggers were identified. [s. 53. (4) (a)]

(157)

2. 3. The licensee failed to ensure that strategies were developed and implemented to respond to resident #02's responsive behaviours.

A review of the plan of care for the resident did not identify behaviours. Amendments to the plan of care made at the time of the inspection provide interventions that had already been found to be ineffective.

There is no evidence that strategies were developed or implemented to respond to resident #02's behaviours that are hazardous to the resident's health and well being.

A staff member interviewed advises that resident #02's responses to interventions vary from one day to the next. This is not identified in the plan of care and there is no evidence of an assessment of these responses to determine the most appropriate interventions.

Three residents and one family member interviewed expressed that they are upset and frustrated that resident #02's behaviours are not being managed.

4. Resident #02's behaviour is a risk to the resident as a result of a pre-existing medical condition. There is no evidence that strategies were developed and implemented to respond to this behaviour and manage this risk to the resident's health and well being. [s. 53. (4) (b)]

5. There is no evidence that PASE recommended interventions for the management of resident #02's behaviours were implemented or evaluated. These recommendations have not been incorporated into the plan of care and staff interviewed are not aware if these approaches have been implemented and evaluated. [s. 53. (4) (b)] (157)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Jan 20, 2014

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 21st day of November, 2013

Signature of Inspector / Signature de l'inspecteur : Pat Powers #157

Name of Inspector / Nom de l'inspecteur : PATRICIA POWERS

Service Area Office / Bureau régional de services : Ottawa Service Area Office